



Phone: 1-877-537-0722
FAX TO: 1-877-537-0720

Division of Medicaid
Pharmacy Prior Authorization Unit
550 High St
Suite 1000
Jackson, MS 39201

MAXIMUM UNIT OVERRIDE
PRIOR AUTHORIZATION REQUEST FORM

BENEFICIARY INFORMATION

Beneficiary's Name: _____ Beneficiary's Medicaid #: _____

City: _____ DOB: _____
Month/ Day/ 4 Digit Year

PRESCRIBER INFORMATION

NPI #: _____

Prescribing Physician: _____ Medicaid ID #: _____

City: _____ State: _____ Phone #: _____

Fax #: _____

I hereby certify that I am the ordering physician/nurse practitioner/physician assistant identified in this form and I deem the prescribed medication to be necessary for the patient listed. I understand that any falsification, omission or concealment of material fact may subject me to civil penalties, fines or criminal prosecution.

Physician's Signature and date

PHARMACY INFORMATION

Dispensing Pharmacy: _____ Provider ID# _____

City: _____ State: _____ Phone: _____

Fax: _____

DRUG/CLINICAL INFORMATION

Drug Name and Strength: _____ Maximum Quantity Requested : _____

Diagnosis: _____ NDC: _____

Medical Justification:

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***Supporting documentation must be available in the patient record.